Plans Ahead for

Smiths in Meat Marketing

#	What To Do	Date Done
1.	Search HBUM for Geo Smith	
	Earl "	
	Don "	
	Doyle "	
	Blaine "	
2.	Find pict of Geo Smith Market in Charleston	
3.	Find pict. of Earl smith MKt in Heber	
4.	" " " " " slaughter house in Heber.	
5.	Sylvan Smith	
6.	Geo Smith in Park City, Charleston, Heber	
7.	Call Gwen Smith Unthank 1890 No 100 E Pleasant Grove 84062 785-4024	

Research Works!

DR. R. R. GREEN
375 E. 2ND ST. No.
HEBER CITY, UTAH
84032

Hutchers

See book of Hailstone

Descendants John Collins'

of Wm Davis

for all Geo Smith

Descendants

HEALTH INSURANCE CLAIM FORM

Type or Pri

RAILROAD EMPLOYEE

INSURED BY **THE TRA**

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☒ OTHER

PA NT & INSURED (SUBSCRIBER) INFORMATION

1. P T'S NAME *(first name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME *(First name, middle*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*	5. PATIENT'S SEX MALE FEMALE	6. INSURED'S I.D. NO. OR MEDICARE NO. *(Include rs)*
	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE – ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES NO B. AN AUTO ACCIDENT YES NO	11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below* SIGNED	DATE	13. *I authorize payment of medical benefits to undersigned physician or supplier for service described below* SIGNED (Insured or authorized person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

24. A DATE OF SERVICE	B PLACE OF SERV-ICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE IDENTIFY( ) *(Explain Unusual Services or Circumstances)*	D DIAGNOSIS CODE	E CHARGES	F